

**DoD Medical Examination Review Board
8034 Edgerton Drive, Suite 132
USAF Academy, Colorado 80840-2200**

ORTHODONTIC QUESTIONNAIRE

NAME: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

Please complete PARTS A and B below and return the form to DoDMERB at the address above: If more space is needed, please use back of form and identify each issue by question number.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

PART A (TO BE COMPLETED BY THE APPLICANT)

Application for Service Academies: I acknowledge that my orthodontic appliances **MUST** be removed and all active treatment **WILL** be completed prior to arriving at the Academy.

Application for ROTC Program(s): I acknowledge that my orthodontic appliances **MUST** be removed and all active treatment **WILL** be completed prior to being commissioned at the end of my ROTC Program. Furthermore, "I acknowledge all financial responsibility for my orthodontic treatment and do not hold the military or ROTC responsible.

Retainer appliances are permissible for all applications provided all active treatment has been completed.

Certification: By signing and dating below, I fully understand the acknowledgement statements above.

Applicant's Signature

Date

PART B (TO BE COMPLETED BY THE APPLICANT'S ORTHODONTIST)

1) Date the patient's orthodontic treatment began: _____

2) Purpose of orthodontic treatment: _____

3) Method of treatment (Edgewise, Begg, etc.): _____

4) Estimated date of removal of orthodontic appliances: _____

5) Type(s) of retainer on top and bottom (Fixed, Removable, etc.): _____

6) Estimated dates of retainer use: _____ to _____

7) Estimated date for ALL active orthodontic treatment to be completed: _____

8) If orthognathic surgery will be involved, please specify: _____

Orthodontist's Signature/Stamp

Date

Orthodontic Questionnaire